Client ID#		
Last Name	**First Name**	**MI**
Date of Birth	Month / Day / Year	

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section
Perinatal Health Unit

Healthy Beginnings Pregnant Service Log

Baby's Due Date:

___ ___ _____
MM DD YYYY

Data Reporting Instructions:
Please document participant's responses to all of the questions below once a month for all enrolled participants. Data are required to be collected and reported for all enrolled participants during the third month of every quarter. Please report all Coordinated Support Services provided during the entire quarter.

Date of Form Completion:	Month	Day	Year
Staff Initials:			

Contact Type: ❑ Phone ❑ Home Visit ❑ Office
❑ Other _____

Are you receiving Prenatal Care?

☐ Yes ☐ No

Date of next visit: ___ ___ _____
MM DD YYYY

Referral needed? ☐ Yes ☐ No

Multivitamin/Folic Acid Consumption:

How often do you take a multivitamin now?

_____ Days a Week

Tobacco Use/Smoking/Secondhand Smoke Exposure:

1) How many cigarettes do you smoke on an average day now?
   a) I don't smoke now
   b) Less than 1 cigarette
   c) 1 to 5 cigarettes
   d) 6 to 10 cigarettes
   e) 11 to 20 cigarettes
   f) 21 or more cigarettes

2) Which of the following statements best describes the rules about smoking inside your home, even if no one who lives in your home is a smoker?
   a) No one is allowed to smoke anywhere inside my home
   b) Smoking is allowed in some rooms or at some times
   c) Smoking is permitted anywhere inside my home

   *Follow the 5A's method of counseling for pregnant women who are currently using tobacco.

Coordinated Support Services:

Document which support services were coordinated/referred during every pregnant service contact: *(check all that apply)*

☐ Breastfeeding/Lactation Consultant
☐ Childbirth Classes
☐ Child Care
☐ Domestic Violence
☐ Doula Services
☐ Education/School Enrollment/GED
☐ Employment/Vocational Rehabilitation
☐ Family Planning Services
☐ Financial Assistance (baby items, clothing, furniture, rent, etc.)
☐ Housing Assistance
☐ Medical Care/Prenatal Care
☐ Mental Health Services
☐ Parenting Education
☐ Smoking Cessation
☐ Substance Use/Abuse Services
☐ Transportation
☐ WIC
☐ Other, please specify: _____

Educational Sessions Attended (Title/Date) — Optional

_____
_____
_____

Service Notes:

Instructions for the Healthy Beginnings Pregnant Service Log

Purpose: For Healthy Beginnings staff to document contacts, referrals and follow-up information, and all required data on program participants.

Instructions: The form must be completed within 14 days of contact with the participant. Submit required data as instructed by the Healthy Beginnings Program Manager. File original form in participant's program record.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the North Carolina Office of Archives and History, Division of Historical Records.